Agency for Healthcare Research and Quality
Advancing Excellence in Health Care

NATIONAL GUIDELINE CLEARINGHOUSE

General

Guideline Title

Transitional care. In: Evidence-based geriatric nursing protocols for best practice.

Bibliographic Source(s)

Lim F, Foust J, Van Cleave J. Transitional care. In: Boltz M, Capezuti E, Fulmer T, Zwicker D, editor(s). Evidence-based geriatric nursing protocols for best practice. 4th ed. New York (NY): Springer Publishing Company; 2012. p. 682-702.

Guideline Status

This is the current release of the guideline.

Recommendations

Major Recommendations

Levels of evidence (I–VI) are defined at the end of the "Major Recommendations" field.

Parameters of Assessment

- Patient populations who are most likely to benefit from transition care interventions are those who are diagnosed with one or more of the following diseases: congestive heart failure (CHF), chronic obstructive pulmonary disease, coronary artery disease, diabetes, stroke, medical and surgical back conditions (predominantly spinal stenosis), hip fracture, peripheral vascular disease, cardiac arrhythmias, deep venous thrombosis, and pulmonary embolism (Coleman et al., 2004 [Level V]).
- Upon admission to an acute care setting, starting at the emergency department (ED); patient evaluation must include referral of vulnerable older adults for transitional care services.
- Compliance with The Joint Commission (TJC) standards in medication reconciliation will be used as one of the quality indicators and predictor in overall patient safety.

Nursing Care Strategies

- General guidelines that may be adapted in implementing transition care strategies based on the Transitional Care Model (TCM) are as follows (Bowles, Naylor, & Foust, 2002 [Level III]):
  - The transitional care nurse (TCN) as the primary coordinator of care to assure consistency of provider across the entire episode of care
  - In-hospital assessment, preparation, and development of an evidence-based plan of care
  - Regular home visits by the TCN with available, ongoing telephone support (7 days per week) through an average of 2 months postdischarge

    - Continuity of medical care between hospital and primary care physicians facilitated by the TCN, accompanying patients to first follow-up visits
    - Coordinate a timely appointment with patient's primary care provider.
    - Comprehensive, holistic focus on each patient's needs including the reason for the primary hospitalization as well as other complicating or coexisting events
    - Active engagement of patients and their family and informal caregivers including education and support
    - Emphasis on early identification and response to health care risks and symptoms to achieve longer term positive outcomes and avoid adverse and untoward events that lead to readmissions
    - Multidisciplinary approach that includes the patient, family, informal and formal caregivers, and health care providers as part of a team
    - Physician–nurse collaboration across episodes of acute care
    - Communication to, between, and among the patient, family and informal caregivers, and health care providers
- Successful and safe transitions demands active patient and informal caregiver involvement. To improve patient advocacy and safety, the nurse can:
    - Promote the "Speak Up" initiative by the TJC in 2002. The brochure "Planning Your Follow Up Care" lists patient-centered and safety-focused questions to be asked by the patients from their health care provider before they are discharged from the hospital (The Joint Commission, 2002).
    - Encourage family involvement and direct them to the "Next Steps in Care" Web site (http://www.nextstepincare.org/).
    - Provide the patient a complete and updated medication reconciliation record. The record should include medications the patient was taking prior to admission, medications prescribed during hospitalization, and medications to be continued upon discharge (Sentinel Event Alert, 2006).
    - Implement evidence-based interventions to reduce transition-related medication discrepancies (Corbett et al., 2010 [Level IV]). Encourage the patient to carry their medication list (e.g., a copy of recent medication reconciliation from a recent hospital admission) and to share the list with any providers of care, including primary care and specialist physicians, nurses, pharmacists, and other caregivers (Sentinel Event Alert, 2006).

Critical Elements of Successful Transitions

- Team approach and preferably nurse led (advanced practice nurse [APN] or specialized nurse) (Coleman et al., 2006; Naylor & Keating, 2008 [Level V])
- Active and early family involvement across transitions (Almborg et al., 2009 [Level IV]; Bauer et al., 2009 [Level V]; Naylor & Keating, 2008 [Level V])
- Proactive patient roles and self-advocacy (Coleman et al., 2006 [Level II])
- High-quality and individualized patient and family discharge instructions (Clark et al., 2005 [Level IV])
- Apply interventions for improving comprehension among patients with low health literacy and impaired cognitive function (Chugh et al., 2009 [Level V]), such as the National Patient Safety Foundation's "Ask Me 3" campaign available at: http://www.npsf.org/askme3/ .
- Patient and informal caregiver empowerment through education
- Commence interventions well before discharge (Bauer et al., 2009 [Level V]).

Coleman identified elements of effective and successful transitions as follows (Coleman, Boult, & American Geriatrics Society Health Care Systems Committee, 2003 [Level VI]):

- Communication between the sending and receiving clinicians regarding a common plan of care
- A summary of care provided by the sending institution (to the next care interface providers)
- The patient's goals and preferences (including advance directives)
- An updated list of problems, baseline physical and cognitive functional status, medications, and allergies
- Contact information for the patient's caregiver(s) and primary care practitioner
- Preparation of the patient and caregiver for what to expect at the next site of care
- Reconciliation of the patient's medication prescribed before the initial transfer with the current regimen
- A follow-up plan for how outstanding tests and follow-up appointments will be completed
- An explicit discussion with the patient and caregiver regarding warning symptoms or signs to monitor that may indicate that the condition has worsened and the name and phone number of who to contact if this occurs

Barriers to Successful Transitions

Coleman identified barriers to effective care transitions at three levels: the delivery system, the clinician, and the patient (Coleman, Boult, & American Geriatrics Society Health Care Systems Committee, 2003 [Level VI]).

The Delivery System Barriers

- The lack of formal relationships between care settings represents a barrier to cross-site communication and collaboration.
- Lack of financial incentives promoting transitional care and accountability in fee-for-service Medicare. Although such incentives exist in Medicare managed care, most plans do not fully address care integration.
- The different financing and contractual relationships that facilities have with various pharmaceutical companies impede effective transitions. As patients are transferred across settings, each facility has incentives to prescribe or substitute medications according to its own medication formulary. This constant changing of medications creates confusion for the patient, caregiver, and receiving clinicians.
- Neither fee-for-service nor managed care Medicare has implemented quality or performance indicators designed to assess the effectiveness of transitional care.
- The lack of information systems designed to facilitate the timely transfer of essential information.

The Clinician Barriers

- The growing reliance on designated institution-based physicians (i.e., "hospitalists") and productivity pressures have made it difficult for primary care physicians to follow their patients when they require hospitalization or short-term rehabilitation.
- Nursing staff shortages have forced an increasing number of acute hospitals to divert patients to other facilities where a completely new set of clinicians, who often do not have timely access to the patient's prior medical records, manages them. Skilled nursing facility (SNF) staff are also overwhelmed and do not have the time or initiative to request necessary information.
- Clinicians do not verbally communicate patient information to one another across care settings.

The Patient Barriers

- Lack of advocacy or outcry from patients for improving transitional care until they or a family member is confronted with the problem firsthand.
- Older patients and their caregivers often are not well prepared or equipped to optimize the care they will receive in the next setting.
- They may have unrealistic expectations about the content or duration of the next phase of care and may not feel empowered to express their preferences or provide input for their care plan.
- Patients may not feel comfortable expressing their concern that the primary factor that led to their disease exacerbation was not adequately addressed.

Follow-up Monitoring

- Institute comprehensive and multidisciplinary transition care planning as soon as the patient is admitted and sustained throughout hospitalization.
- Identify transition care team members and perform periodic role re-assessment, including roles of informal caregivers.
- Incorporate continuous quality improvement criteria into transition care programs such as monitoring for rehospitalization of targeted older adult, quality of discharge instruction, and medication reconciliation.
- Develop ongoing transitional care educational programs for both formal and informal caregivers, using high-tech and traditional media.
- Provide orientation and ongoing education on procedures for reconciling medications to all health care providers, including ongoing monitoring (Sentinel Event Alert, 2006).
- Periodic "debriefing" of high-risk discharges as quality improvement strategy.
- Improve recognition of condition changes or adverse events caused by medications.
- Increase patient and caregivers' knowledge concerning action steps if condition worsens including who to contact and 24-hour contact information.

Definitions:

Levels of Evidence

Level I: Systematic reviews (integrative/meta-analyses/clinical practice guidelines based on systematic reviews)

Level II: Single experimental study (randomized controlled trials [RCTs])

Level III: Quasi-experimental studies

Level IV: Non-experimental studies

Level V: Care report/program evaluation/narrative literature reviews

Level VI: Opinions of respected authorities/consensus panels

AGREE Next Steps Consortium (2009). Appraisal of guidelines for research & evaluation II. Retrieved from http://www.agreetrust.org/?o=1397 .

Adapted from: Melnyck, B. M. & Fineout-Overholt, E. (2005). Evidence-based practice in nursing & health care: A guide to best practice. Philadelphia, PA: Lippincott Williams & Wilkins and Stetler, C.B., Morsi, D., Rucki, S., Broughton, S., Corrigan, B., Fitzgerald, J., et al. (1998). Utilization-focused integrative reviews in a nursing service. Applied Nursing Research, 11(4) 195-206.

Clinical Algorithm(s)

None provided

Scope

Disease/Condition(s)

Diseases and conditions requiring transitional care, such as:

- Congestive heart failure
- Chronic obstructive pulmonary disease
- Coronary artery disease
- Diabetes
- Stroke
- Medical and surgical back conditions (predominantly spinal stenosis)
- Hip fracture
- Peripheral vascular disease
- Cardiac arrhythmias
- Deep venous thrombosis
- Pulmonary embolism

Guideline Category

Evaluation

Management

Treatment

Clinical Specialty

Family Practice

Geriatrics

Nursing

Intended Users

Advanced Practice Nurses

Allied Health Personnel

Health Care Providers

Hospitals

Nurses

Physician Assistants

Physicians

Guideline Objective(s)

To provide a standard of practice protocol to:

- Assist nurses in assuming a proactive role in transitional care across health care settings
- Assist nurses in identifying barriers to successful transitions and offering sustainable solutions
- Increase coordination of care during transitions across health care settings amongst all members of the health care system, including the family and informal caregivers

Target Population

Adults age 65 and older across health care settings (hospitals, nursing homes, assisted living, homecare)

Interventions and Practices Considered

Assessment/Evaluation

1. Determining patient population who are most likely to benefit from transition care interventions
2. Assessment on admission
3. Patient evaluation including referral of vulnerable older adults for transitional care services
4. Compliance with The Joint Commission (TJC) standards in medication reconciliation

Management

1. Transitional care nurse as primary coordinator of care
2. Evidence-based plan of care
3. Regular home visits
4. Continuity of care
5. Timely appointment with patient's primary care provider
6. Focus on patient's needs
7. Engagement of patient and family/caregivers
8. Early identification and response to health care risks
9. Multidisciplinary approach
10. Collaboration among care providers

Major Outcomes Considered

- Patient satisfaction and involvement with care during hospitalization and transitions of care across health care settings
- Patient feeling of empowerment in making health care decision
- Rate of rehospitalization and emergency department visits because of primary disease and comorbidities
- Rate of successful and safe health care transitions

Methodology

Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

Although the Appraisal of Guidelines for Research and Evaluation (AGREE) instrument (described in Chapter 1 of the original guideline document, *Evidence-based Geriatric Nursing Protocols for Best Practice,* 4th ed.) was created to critically appraise clinical practice guidelines, the process and criteria can also be applied to the development and evaluation of clinical practice protocols. Thus, the AGREE instrument has been expanded (i.e., AGREE II) for that purpose to standardize the creation and revision of the geriatric nursing practice guidelines.

The Search for Evidence Process

Locating the best evidence in the published research is dependent on framing a focused, searchable clinical question. The PICO format—an acronym for population, intervention (or occurrence or risk factor), comparison (or control), and outcome—can frame an effective literature search. The editors enlisted the assistance of the New York University Health Sciences librarian to ensure a standardized and efficient approach to collecting evidence on clinical topics. A literature search was conducted to find the best available evidence for each clinical question addressed. The results were rated for level of evidence and sent to the respective chapter author(s) to provide possible substantiation for the nursing practice protocol being developed.

In addition to rating each literature citation as to its level of evidence, each citation was given a general classification, coded as "Risks," "Assessment," "Prevention," "Management," "Evaluation/Follow-up," or "Comprehensive." The citations were organized in a searchable database for later retrieval and output to chapter authors. All authors had to review the evidence and decide on its quality and relevance for inclusion in their chapter or protocol. They had the option, of course, to reject or not use the evidence provided as a result of the search or to dispute the applied level of evidence.

Developing a Search Strategy

Development of a search strategy to capture best evidence begins with database selection and translation of search terms into the controlled vocabulary of the database, if possible. In descending order of importance, the three major databases for finding the best primary evidence for most clinical nursing questions are the Cochrane Database of Systematic Reviews, Cumulative Index to Nursing and Allied Health Literature (CINAHL), and Medline or PubMed. In addition, the PsycINFO database was used to ensure capture of relevant evidence in the psychology and behavioral sciences literature for many of the topics. Synthesis sources such as UpToDate® and British Medical Journal (BMJ) Clinical Evidence and abstract journals such as *Evidence Based Nursing* supplemented the initial searches. Searching of other specialty databases may have to be warranted depending on the clinical question.

It bears noting that the database architecture can be exploited to limit the search to articles tagged with the publication type "meta-analysis" in Medline or "systematic review" in CINAHL. Filtering by standard age groups such as "65 and over" is another standard categorical limit for narrowing for relevance. A literature search retrieves the initial citations that begin to provide evidence. Appraisal of the initial literature retrieved may lead the searcher to other cited articles, triggering new ideas for expanding or narrowing the literature search with related descriptors or terms in the article abstract.

Number of Source Documents

Not stated

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Levels of Evidence

Level I: Systematic reviews (integrative/meta-analyses/clinical practice guidelines based on systematic reviews)

Level II: Single experimental study (randomized controlled trials [RCTs])

Level III: Quasi-experimental studies

Level IV: Non-experimental studies

Level V: Care report/program evaluation/narrative literature reviews

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Methods Used to Analyze the Evidence

Review of Published Meta-Analyses

Systematic Review

Description of the Methods Used to Analyze the Evidence

Not stated

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

Not stated

Rating Scheme for the Strength of the Recommendations

Not applicable

Cost Analysis

A formal cost analysis was not performed and published cost analyses were not reviewed.

Method of Guideline Validation

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

Not stated

Evidence Supporting the Recommendations

References Supporting the Recommendations

Almborg AH, Ulander K, Thulin A, Berg S. Discharge planning of stroke patients: the relatives' perceptions of participation. J Clin Nurs. 2009 Mar;18(6):857-65. PubMed

Bauer M, Fitzgerald L, Haesler E, Manfrin M. Hospital discharge planning for frail older people and their family. Are we delivering best practice? A review of the evidence. J Clin Nurs. 2009 Sep;18(18):2539-46. [40 references] PubMed

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Corbett CF, Setter SM, Daratha KB, Neumiller JJ, Wood LD. Nurse identified hospital to home medication discrepancies: implications for improving transitional care. Geriatr Nurs. 2010 May-Jun;31(3):188-96. PubMed

Naylor M, Keating SA. Transitional care. Am J Nurs. 2008 Sep;108(9 Suppl):58-63; quiz 63. [41 references] PubMed

Sentinel Event Alert. Issue 35: Using medication reconciliation to prevent errors. Joint Commission; 2006.

The Joint Commission. Speak up: planning your follow-up care. [internet]. Oakbrook Terrace (IL): The Joint Commission; 2002

Type of Evidence Supporting the Recommendations

The type of supporting evidence is identified and graded for selected recommendations (see the "Major Recommendations" field).

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

Patient

- Improved patient satisfaction, increased involvement with care during hospitalization and transitions of care across health care settings
- Increased feeling of empowerment in making health care decisions
- Reduced rehospitalization and emergency department visits because of primary disease and comorbidities

Clinician

- Increased nurse involvement in leading transition care teams
- Enhanced staff training of transitional care by a multidisciplinary team
- Inclusion of patient's transitional care needs during in-hospital "hand off"
- Improved medication reconciliation throughout all transition interfaces

Informal Caregiver

- Improved informal caregiver satisfaction and exercise proactive roles during transitions across health care settings
- Increased informal caregiver participation in all transitions interfaces

Institution

- Adoption of evidence-based transitional care models (TCMs) and provision of logistic support
- Provision of orientation and on-going education on transitional care strategies
- Introduction of transitional care content into nursing core curriculum both in baccalaureate and graduate levels

Potential Harms

Not stated

Implementation of the Guideline

Description of Implementation Strategy

An implementation strategy was not provided.

Implementation Tools

Chart Documentation/Checklists/Forms

Mobile Device Resources

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Getting Better

Living with Illness

Staying Healthy

IOM Domain

Effectiveness

Patient-centeredness

Identifying Information and Availability

Bibliographic Source(s)

Lim F, Foust J, Van Cleave J. Transitional care. In: Boltz M, Capezuti E, Fulmer T, Zwicker D, editor(s). Evidence-based geriatric nursing protocols for best practice. 4th ed. New York (NY): Springer Publishing Company; 2012. p. 682-702.

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2012

Guideline Developer(s)

Hartford Institute for Geriatric Nursing - Academic Institution

Guideline Developer Comment

The guidelines were developed by a group of nursing experts from across the country as part of the Nurses Improving Care for Health System Elders (NICHE) project, under sponsorship of the Hartford Institute for Geriatric Nursing, New York University College of Nursing.

Source(s) of Funding

Hartford Institute for Geriatric Nursing

Guideline Committee

Not stated

Composition of Group That Authored the Guideline

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Financial Disclosures/Conflicts of Interest

Not stated

Guideline Status

This is the current release of the guideline.

Guideline Availability

Electronic copies: Available from the Hartford Institute for Geriatric Nursing Web site .

Copies of the book *Evidence-Based Geriatric Nursing Protocols for Best Practice*, 4th edition: Available from Springer Publishing Company, 536 Broadway, New York, NY 10012; Phone: (212) 431-4370; Fax: (212) 941-7842; Web: www.springerpub.com .

Availability of Companion Documents

The following is available:

- *Try This*® - issue 26: The Transitional Care Model (TCM): hospital discharge screening criteria for high risk older adults. New York (NY): Hartford Institute for Geriatric Nursing; 2 p. 2009. Electronic copies: Available in Portable Document Format (PDF) from the Hartford Institute of Geriatric Nursing Web site .

The ConsultGeriRN app for mobile devices is available from the Hartford Institute for Geriatric Nursing Web site .

Patient Resources

None available

NGC Status

This NGC summary was completed by ECRI Institute on June 25, 2013. The information was verified by the guideline developer on August 6, 2013.

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